# Ostomy Prescription For Medical Supplies

Tri-State Medical Supply LLC
6392 Hwy 51
Pope, MS 38658
Ph: (662)267-3112 Fax: (662)267-3289

| | | |
|---|---|---|
| **Patient Number:** | **Address1:** | **State:** |
| **Patient Name:** | **Address2:** | **Zip:** |
| **Patient DOB:** | **City:** | **Discharge Date:** |

**Instructions: Please fill in all sections and fax back to 662-267-3289. Please call 662-267-3112 with any questions. If you have any changes, please cross out, write in correction, sign and date it.**

## Section A — DIAGNOSIS

___ Colostomy Z93.3 / Z43.3 ___ Ileostomy Z93.2 / Z43.2 ___ Urostomy Z93.6 / Z43.6

## Section B — PATIENT SUPPLIES

| Select the products you are prescribing | Per Day Usage | Quantity you are prescribing |
|---|---|---|
| ☐ Drainable Pouches | 1x day | 20 / mo. |
| ☐ Closed Pouches | 2x day | 60 / mo. |
| ☐ Skin Barriers with Flange | 1x day | 20 / mo. |
| ☐ Skin Barrier Strips | 1xd | 20 / mo. |
| ☐ Barrier Rings | 1x day | 20 / mo. |
| ☐ Conformable Seals | 1x day | 20 / mo. |
| ☐ Stoma powder | 1x day | 1oz. / mo. |
| ☐ Ostomy Belt | 1 / mo. | 1 / mo. |
| ☐ Secu-Rings | 1x day | 20 / mo. |
| ☐ Skin Barrier Paste | 1x day | 4oz. / mo. |
| ☐ Bedside Drainage Bag | 2 / mo. | 2 / mo. |
| ☐ Skin Barrier Wipes | 2x day | 50 / mo. |

| WOUND CARE SUPPLIES DX Code: _____ | Size | Indicate Daily Frequency | Indicate Dispensing Quantity |
|---|---|---|---|
| ☐ Gauze Sponges | | | |
| ☐ Gauze Rolls | | | |
| ☐ Tape | | | |
| ☐ ABD Pads | | | |

| Select the products you are prescribing | Per Day Usage | Quantity you are prescribing |
|---|---|---|
| ☐ Deodorant | 1xd | 16oz / mo. |
| ☐ Adhesive | 1x day | 4oz. / mo. |
| ☐ Gauze pad for cleaning, 100 | 4x day | 100 / mo. |
| ☐ Stoma Cap | 1x day | 30 / mo. |
| ☐ Micropore Tape | 1.33 sq. in./day | 2 rolls / mo. |
| ☐ Osteo- EZ Vents | 4x day | 100 / mo. |
| ☐ Filters | 1x day | 30 / mo. |
| ☐ Drain Bottle | 1 / mo. | 1 / mo. |
| ☐ Appliance Cleaner | 1x day | 16oz. / mo. |
| ☐ Adhesive Remover | 2x day | 50 / mo. |
| ☐ Irrigation Sleeves | 1 / wk. | 4 / mo. |
| ☐ Irrigation Supply Set | 1 / mo. | 1 / mo. |

| OTHER DX Code: _____ | Size | Indicate Daily Frequency | Indicate Dispensing Quantity |
|---|---|---|---|
| ☐ Other Ref # | | | |
| ☐ Other Ref # | | | |
| ☐ Other Ref # | | | |
| ☐ Gloves | | | |

## Section C — DURATION OF NEED: 99 months (lifetime) unless you specify otherwise here: _____

By my signature below, I am stating that the patient is/was being treated by me. All information contained on the Rehab Program Prescription For Medical Supplies form accurately reflects the patient's condition and the treatment regimen I prescribed. My medical records for this patient substantiate the prescribed use of products. I will maintain a copy of this signed original Rehab Program Prescription For Medical Supplies form in the patient's medical record file and make it available for Medicare/Insurer audit purposes.

## Section D — PHYSICIAN INFO

Name: Phone:
Address:
Fax:
NPI#:

## Section E — PHYSICIAN SIGNATURE

Signature

Printed Name Date

**Please initial and date all changes on form.**
**Please send a copy of your chart notes along with this request.**